No. 93-120

In the Supreme Court of the United States

OCTOBER TERM, 1993

THOMAS JEFFERSON UNIVERSITY, D/B/A
THOMAS JEFFERSON UNIVERSITY HOSPITAL, PETITIONER

v.

DONNA E. SHALALA,
SECRETARY OF HEALTH AND HUMAN SERVICES

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

BRIEF FOR THE RESPONDENT

DREW S. DAYS, III
Solicitor General

HARRIET S. RABB
General Counsel

FRANK W. HUNGER
Assistant Attorney General

DARREL J. GRINSTEAD
Associate General Counsel

EDWIN S. KNEEDLER
Deputy Solicitor General

HENRY R. GOLDBERG
Deputy Associate General Counsel

AMY L. WAX
Assistant to the Solicitor General

THOMAS W. COONS
Supervisory Attorney

ROBERT V. ZENER
ROBERT D. KAMENSHINE
Attorneys

Department of Health and Human Services
Washington, D.C. 20201

Department of Justice
Washington, D.C. 20530
(202) 514-2217

QUESTION PRESENTED

Under Medicare regulations, a hospital's "allowable cost[s]," for which reimbursement is available, may include the cost of clinical training programs for interns and residents, known as graduate medical education (GME) programs. 42 C.F.R. 413.85(a). The regulations further provide, however, that reimbursement is available for medical education costs only "[u]ntil communities undertake to bear these costs," and that "it is not intended that [the Medicare Program] should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units." 42 C.F.R. 413.85(c).

The question presented is:

Whether the Secretary reasonably determined that 42 C.F.R. 413.85(c) bars petitioner Thomas Jefferson Hospital from obtaining Medicare reimbursement of GME program costs that previously were absorbed by its affiliated medical school.

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OPINIONS BELOW

The order of the court of appeals (Pet. App. 1a-2a) and the opinion of the district court (Pet. App. 3a-25a) are unreported. The judgment of the court of appeals is noted at 993 F.2d 879 (Table).

JURISDICTION

The judgment of the court of appeals was entered on April 21, 1993. Pet. App. 1a. The petition for a writ of certiorari was filed on July 20, 1993, and was granted on January 10, 1994 (114 S. Ct. 680). The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

REGULATORY PROVISION INVOLVED

The relevant regulatory provision, 42 C.F.R. 413.85(c), is set forth at J.A. 40-41.

STATEMENT

This case involves the application of a regulation, 42 C.F.R. 413.85(c), that prohibits Medicare reimbursement of increased costs resulting from a "redistribution of costs" of educational activities from a hospital's affiliated educational institution (such as a medical school) to the hospital. The regulation further states that Medicare will reimburse the costs of medical education only "[u]ntil" the community bears them. In this case, the court of appeals held that Section 413.85(c) does not permit petitioner Thomas Jefferson University Hospital to receive Medicare reimbursement for costs incurred in fiscal year 1985 by its affiliated medical school in connection with the Hospital's educational programs for interns and residents, because the medical school had paid those costs in the past.[1]

1. a. Title XVIII of the Social Security Act establishes the federally funded Medicare Program, which provides health insurance for the elderly and disabled. 42 U.S.C. 1395 *et seq.* Part A of the Program provides insurance for inpatient hospital and related post-hospital services.[2] Persons covered by Medicare may receive medical services at any facility participating in the Medicare Program as a

[1] The Sixth Circuit reached a contrary result in *Ohio State University* v. *Secretary, United States Dep't of Health & Human Services*, 996 F.2d 122 (6th Cir. 1993), petition for cert. pending, No. 93-696 (filed Nov. 1, 1993).

[2] There also is a voluntary supplementary insurance program (Part B), which covers physicians' charges and other medical services. 42 U.S.C. 1395k, 1395*l*, 1395x(s).

"provider of services." 42 U.S.C. 1395d, 1395x(u). Providers generally are reimbursed for their "reasonable" and "necessary" costs of providing medical services to eligible beneficiaries. 42 U.S.C. 1395x(v)(1)(A); 42 C.F.R. 413.9(b). The "reasonable cost" of services is to be determined in accordance with regulations, issued by the Secretary of Health and Human Services, that establish the "method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions * * * and services." 42 U.S.C. 1395x(v)(1)(A). In prescribing the regulations, the Secretary is to consider, among other things, "the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment * * * to providers of services." *Ibid.*; see also 42 U.S.C. 1395hh (general authorization of regulations).

Under implementing regulations, certain costs of educational programs for health professional trainees, such as nurses, paramedical personnel, physician's assistants, and interns and residents, may be "allowable cost[s]" for which a hospital is able to receive reimbursement under Medicare Part A. 42 C.F.R. 413.85(a). Included in that category are in-hospital clinical training programs for post-graduate physicians, known as graduate medical education (GME) programs. To be eligible for reimbursement, the claimed costs must be for educational services that are "related to the care of [Medicare] beneficiaries." 42 C.F.R. 413.9(a).[3]

[3] Reimbursement is available not only for services furnished by the hospital, but also for services furnished by the hospital's affiliated medical school in connection with the hospital's educational programs. However, the amount of reimbursement is limited in those circumstances by the general "related organizations" regulation, which provides that "costs applicable to services * * * furnished to the provider by organizations related to the provider by common ownership

Reimbursement is also subject to two additional conditions. First, 42 C.F.R. 413.85(c) provides that "[a]lthough the intent of the [Medicare Program] is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, it is not intended that [the Medicare Program] should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units." This is known as the "anti-redistribution" principle. Second, 42 C.F.R. 413.85(c) states that the costs of educational activities "should be borne by the community," but that "[u]ntil communities undertake to bear these costs, the [Medicare Program] will participate appropriately in the support of these activities." This is known as the "community support" principle; it independently bars reimbursement of costs that have in the past been paid out of private and public sources of funds other than Medicare.

b. In 1983, Congress changed the method of reimbursement for inpatient services by instituting the Prospective Payment System (PPS), which establishes fixed payment rates for various inpatient services. See 42 U.S.C. 1395ww (d), as added by Pub. L. No. 98-21, § 601(e), 97 Stat. 152-158 (1983). But Congress retained the "reasonable cost" reimbursement system for certain costs, including those of medical education. 42 C.F.R. 1395ww(a)(4). Thus, costs incurred in connection with GME programs were excluded from the PPS scheme, and continued to be reimbursed on a retrospective, "reasonable cost" basis. Pet. App. 5a-6a.

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or control are includable in the allowable cost of the provider at the cost to the related organization." 42 C.F.R. 413.17(a). In addition, as explained in the text, *infra*, reimbursement is further conditioned in the present context on compliance with the "anti-redistribution" and "community support" principles in the regulation (42 U.S.C. 413.85) that specifically governs reimbursement of educational activities.

In 1986, however, Congress adopted a new payment methodology for some of providers' approved educational expenses, effective for cost-reporting years beginning on or after July 1, 1985. Subject to appropriate updating, the calculation of GME costs to be reimbursed in all subsequent years is based on the amount of costs claimed by the provider for a fiscal year beginning between October 1, 1983, and September 30, 1984 (the base year). See Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, Pub. L. No. 99-272, § 9202(a), 100 Stat. 171 (1986), codified at 42 U.S.C. 1395ww(h); 42 C.F.R. 413.86(e)(1)(i)(A).[4] The base year coincides with petitioner Thomas

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[4] The COBRA of 1985 distinguishes between "direct graduate medical education costs," which are reimbursed through the "base year" methodology in 42 U.S.C. 1395ww(h), and "indirect costs" associated with post-graduate training programs, which are covered by a separate section enacted by the COBRA of 1985 (see 42 U.S.C. 1395ww(d)(5)(B)) and which are reimbursed through the PPS system applicable to direct patient services. In explaining the difference between the two types of costs under preexisting law, the Conference Report on the COBRA of 1985 stated:

> The medicare program provides reimbursement for both the direct and indirect costs of medical education incurred by teaching hospitals. The direct costs of approved medical education programs (such as salaries for residents and teachers and classroom costs) are excluded from the prospective payment system, and are reimbursed on a reasonable cost basis. The indirect costs are increased patient care costs associated with teaching programs due to such factors as increased diagnostic testing, increased numbers of procedures prescribed, higher staffing ratios, and a more severely ill patient population.

H.R. Conf. Rep. No. 453, 99th Cong., 1st Sess. 455 (1985); see also *id.* at 86-87, 455-458 (describing changes in law related to indirect costs); *id.* at 102-106, 481-487 (describing changes related to direct costs). Under the quoted description, all costs attributable to the operation of a provider's educational programs (including overhead and costs incurred by an affiliated medical school) are "direct" costs to

Jefferson University Hospital's 1985 fiscal year (July 1, 1984-June 30, 1985). See American Hospital Ass'n *et al.* Amicus Br. (AHA Br.) at 5. Thus, the amount of reimbursement allowed to petitioner for GME costs during the period at issue in this case will determine its level of reimbursement for GME programs in all years to come.

2. Thomas Jefferson University Hospital (the Hospital) is a teaching hospital operated by petitioner Thomas Jefferson University, a private not-for-profit educational institution. The Hospital operates Medicare-approved graduate medical education (GME) programs for interns and residents. The GME programs are conducted in the Hospital by faculty of the University's College of Medicine (the Medical School). At the Medicare Program's inception in 1966, the Hospital became an approved provider. Since 1974, the Hospital has received Medicare reimbursement for certain categories of costs related to its GME programs. Between 1974 and 1983, the Hospital obtained reimbursement for salaries it paid to Medical School faculty (or to the Medical School itself) for GME-related services rendered by the faculty in the Hospital. The Hospital also claimed reimbursement for salaries it paid to residents. Pet. App. 8a-9a.

In 1985, the Hospital commissioned an accounting firm to conduct a cost study on which to base its reimbursement claim for fiscal year 1985.[5] Anticipating the results of the

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be reimbursed through the base-year methodology in 42 U.S.C. 1395ww(h), notwithstanding the occasional references by the parties and in the proceedings below to "indirect costs."

[5] A prior review by the Hospital led to a claim for clerical and office space costs in 1984, which the intermediary mistakenly allowed. The intermediary realized its error during the PRRB hearing on the Hospital's claim for fiscal year 1985, but by that time the period during which the intermediary could reopen the Hospital's 1984 cost

not-yet-completed study, the Hospital made adjustments to its 1985 cost report to include additional amounts it estimated would be supported by that study. Specifically, the Hospital increased its claim for resident and intern costs by $4,000,000 (from the $4,737,219 already included for GME costs to $8,737,219). The Hospital also increased the amount it claimed for physician administrative costs by $452,000 (to $2,032,380) to claim expenses for which it had not previously sought reimbursement under Medicare—overhead costs incurred by the Medical School for space, equipment, and general clerical and administrative services in support of the Hospital's GME programs. Pet. App. 9a-10a, 32a, 41a; Pet. C.A. App. 88. After completion of the cost study, the Hospital modified its 1985 cost report to claim $6,614,724 in GME costs and $2,191,481 in general administrative costs. The intermediary allowed $4,183,480 in GME costs (later increased by settlement to $4,635,633) and $1,761,478 in physician administrative costs. Pet. App. 10a, 41a-42a. The intermediary allowed only the costs it initially had determined to be allowable—*i.e.*, those salary and overhead costs that had been claimed in prior years, increased by an inflation factor. It denied the additional increases proposed by the Hospital as an improper attempt to redistribute costs from an educational unit to a patient care unit, in violation of 42 C.F.R. 413.85(c). Pet. App. 9a-10a.[6]

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report under 42 C.F.R. 405.1885 had expired. See Pet. App. 9a & n.3, 35a n.10. The additional costs mistakenly allowed for fiscal year 1984 are not at issue here.

[6] According to petitioner's calculation (Pet. Br. 11-12 & n.7), the settlement (see J.A. 2) left $1,979,091 of costs in dispute. Because approximately 35% of the Hospital's allowable costs were paid by Medicare in fiscal year 1985 (apportioned based on usage of the Hospital by Medicare patients), Medicare would be required to pay petitioner approximately $700,000 if the Secretary were required to allow the additional $1,979,091. See Pet. Br. 12 & n.8.

3. The Hospital appealed to the Provider Reimbursement Review Board (PRRB), which reversed the intermediary's decision and allowed reimbursement of the full costs shown in the cost study. Pet. App. 38a-60a; see 42 U.S.C. 1395*oo*(a). The PRRB noted that the term "redistribution" in 42 C.F.R. 413.85(c) had not been defined in the regulations or in other program instructions, and that it is prefaced in 42 C.F.R. 413.85(c) by a statement that the Medicare Program will share in the support of educational activities customarily or traditionally carried on by providers. For that reason, and "[i]n the absence of further clarification," the PRRB believed that "the focus of the regulation with respect to redistribution is on educational 'activities,' and not the 'cost' associated with the activity." Pet. App. 59a. "Accordingly," the PRRB concluded, "the concept of redistribution would not apply unless the educational program was a new activity being performed by the provider." *Ibid.* The PRRB held that there was no redistribution in this case because "the Provider is merely claiming additional support costs for the GME programs it has historically operated," based on a "refinement of its methodology for determining GME costs." *Ibid.*

4. The Acting Administrator of the Health Care Financing Administration (on behalf of the Secretary) modified the PRRB's decision. Pet. App. 28a-37a; see 42 U.S.C. 1395*oo*(f)(1). He initially observed that upon implementation of PPS and the corresponding provision for pass-through of medical education costs under the "reasonable cost" standard, it "became apparent" that some teaching hospitals "were attempting to claim costs not previously the responsibility of the Provider or reimbursed by Medicare." Pet. App. 34a. Under "established Medicare policy," the Acting Administrator explained, that practice constitutes "an improper redistribution of teaching institution costs to hospital medical education costs." *Ibid.*

Similarly in this case, the Acting Administrator concluded that "[t]he Provider has attempted to radically expand the types of costs claimed * * * for educational activities." Pet. App. 35a. He recognized that Congress intended that, "until the community undertakes to bear such education costs in some way, the Medicare program should bear some portion of the costs of educational activities as an element in the costs of patients care." *Ibid.* But here, he explained (*ibid.*):

> Evidence in the record shows that these cost[s] have been historically borne by the community. The Medicare program was enacted to provide a hospital insurance and basic protection against the costs of hospital care for the aged, and not intended to subsidize medical education programs already supported by the community.

Against this background, the Acting Administrator concluded that the PRRB "improperly determined that the Provider's failure to claim [the disputed] costs in an earlier cost year was an 'error', which it was just attempting to correct"; in his view, that failure should be considered "evidence of the communit[y's] support for these activities." Pet. App. 35a. "To allow the community to withdraw that support and pass these costs to the Medicare program would result in a redistribution of costs in violation of 42 CFR 413.85(c)," which is "precise[ly] [what] Congress intended to prevent." Pet. App. 35a.[7]

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[7] The Acting Administrator further concluded that, despite petitioner's reliance on the "related organizations" principle in 42 C.F.R. 413.17 (see note 3, *supra*), the general and administrative costs of the Medical School would not in any event be allowable medical education costs. The Acting Administrator explained that "the purpose of the related organization principle is to avoid the payment of a profit factor to the provider through a related organization and to avoid payment of artificially inflated costs which may be generated from less

4. The district court sustained the Secretary's decision. Pet. App. 3a-25a. "Adopting a plain meaning approach," it agreed with the Secretary that to qualify for reimbursement, costs of educational activities must satisfy two criteria under 42 C.F.R. 413.85(c): (a) they must "have not been borne traditionally by the community," and (b) they must "have not been redistributed from an educational institution to a patient care unit." Pet. App. 15a. In the court's view, the Secretary properly found that the Hospital had run afoul of both criteria.[8]

a. The district court noted that the regulation does not define "community support," and it found "reasonable

than arms-length bargaining"; it "does not expand items or services allowable under Medicare principles." Pet. App. 36a.

The district court, in sustaining the Acting Administrator's decision, agreed with his conclusion on this point. The court accepted the Secretary's explanation that 42 C.F.R. 413.17 "is a general regulation applied at the threshold to all costs incurred by a related organization in delivering patient care," and that costs still must meet more specific requirements elsewhere in the regulations, such as those in 42 C.F.R. 413.85(c) that govern educational activities. Pet. App. 23a. The court also explained that "[a]pplication of the related organization principle in the manner urged by the Hospital would render the [anti-] redistribution principle almost completely meaningless, a result in conflict with the most basic rules of statutory construction as well as commonsense." *Id.* at 24a. Petitioner does not raise the related organization issue in this Court. See Pet. i; Pet. Br. i.

[8] As a threshold matter, the court rejected, as "in conflict with the plain language" of 42 C.F.R. 413.85(c), the Hospital's argument that the community support and anti-redistribution principles apply "only to the academic or 'classroom' portions of the Hospital's training programs and not to clinical training programs." Pet. App. 16a. The court pointed out that the training of interns and residents "is predominantly, if not exclusively, clinical in nature," and that "[t]he regulation simply contains no language evidencing an intent to distinguish between academic and clinical training for purposes of determining the allowability of costs claimed." *Id.* at 16a-17a.

and entitled to deference" the interpretation in the Acting Administrator's decision that community support includes "tuition, hospital fees, grants, bequests, and state funded support from Pennsylvania and Delaware," Pet. App. 18a (quoting *id.* at 32a). The court found that definition consistent both with the position the Secretary had taken in other cases involving disputed claims for GME costs, and with reimbursement principles adopted by the American Hospital Association. *Id.* at 18a. The court next held that the Secretary's finding that the increased GME costs claimed by petitioner for fiscal year 1985 had traditionally been borne by the community was supported by substantial evidence. *Id.* at 19a. It pointed to testimony before the PRRB establishing that the costs had previously been borne by the Medical School and that the ultimate sources of funding included "appropriations from the Commonwealth of Pennsylvania and the State of Delaware as well as gifts, grants and alumni giving endowments." *Ibid.*

The court rejected the suggestion that a provider may look to Medicare for increased support when community support decreases. Pet. App. 19a-20a. In the court's view, the regulation's language "evidences Congress' express intent" that the community should bear the costs of medical education programs and that Medicare would "participate appropriately in the support of these activities" only "*until* [ ] communities undertake to bear these costs." *Id.* at 20a (quoting 42 C.F.R. 413.85(c) (emphasis added by the court)). "Nothing in the regulation suggests * * * that a provider may seek to compensate for a decline in community support by escalating costs claimed from the Medicare program." Pet. App. 20a. The court also explained that petitioner's interpretation would conflict with the purpose of the 1983 amendments to the Medicare program of "stemming the spiraling costs of the Medicare program to prevent exhaustion of the fund and achieving a level of budget neutrality." *Ibid.*

b. On the issue of redistribution, the court first rejected petitioner's position "that the [anti-]redistribution principle operates to prohibit only the impermissible shifting of 'activities' from an educational unit to a patient care unit and does not apply to the shifting of 'costs' for activities customarily and traditionally carried on [by] the provider." Pet. App. 21a. The court instead "concur[red] with the Secretary's conclusion that the regulation admits of only one interpretation, to wit, if the costs of activities customarily and traditionally carried on by providers in conjunction with their operations have been absorbed by an educational unit, such costs may not later be redistributed to a patient care unit." *Id.* at 21a-22a. The court further found the Secretary's application of the regulation here to be "consistent with earlier applications in other disputes concerning the proper level of reimbursement for educational activities." *Id.* at 22a. "It is uncontroverted," the court noted, "that the excess costs claimed by the Hospital in fiscal year 1985 previously were borne by the Medical School." *Ibid.* Thus, "despite careful consideration of the Hospital's assertion that its increased claim represented a refinement of its cost-finding techniques rather than a redistribution of costs," the court "agree[d] with the Secretary's conclusion that the increased claim for reimbursement represents an impermissible redistribution of costs from an educational institution, the Medical School, to a patient care institution, the Hospital." *Ibid.*

5. The court of appeals affirmed, on the briefs, without opinion. Pet. App. 1a-2a.

SUMMARY OF ARGUMENT

A. In promulgating 42 C.F.R. 413.85(c), the Secretary of Health and Human Services exercised express statutory authority to determine what shall be considered the "reasonable cost" of delivering patient care services to Medicare beneficiaries. Although Congress recognized that educational activities enhance the quality of medical care in provider institutions, it intended, at the Program's inception, that Medicare should bear the cost of these activities only "until the community undertakes to bear such education costs." S. Rep. No. 404, 89th Cong., 1st Sess. Pt. 1, at 36 (1965); H.R. Rep. No. 213, 89th Cong., 1st Sess. 32 (1965).

In accordance with Congress's intent, the Secretary has fashioned and interpreted 42 C.F.R. 413.85(c) to establish a general "community support" principle that bars reimbursement of costs incurred in connection with a provider's educational programs if those costs have previously been paid by the community. In a case such as this one, in which a provider's affiliated medical school has in the past furnished support for the provider's educational program (and the provider has not previously claimed Medicare reimbursement for those costs), the community support principle bars Medicare reimbursement of those costs. The Secretary's interpretation of the anti-redistribution clause of the regulation reinforces the community support principle. Under that clause, any attempt to pass on to Medicare costs that have previously been paid by a medical school is a forbidden "redistribution of costs" from an educational unit to a patient care unit. The regulation thus furthers Congress's intent that the community should be the preferred source of support for hospital educational programs and that Medicare should be a payor of last resort.

B. The Secretary's interpretation of 42 C.F.R. 413.85(c) is, at the very least, a reasonable construction of the language of the regulation itself. First, the regulation contemplates Medicare reimbursement of educational costs only "[u]ntil" the community bears the costs, and in this case the community, through the Medical School,

already paid the costs at issue. Second, the final clause of 42 C.F.R. 413.85(c) states that, although Medicare will make reimbursement for some medical education costs, "it is not intended that [the Medicare Program] should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units." Although petitioner asserts that this clause does not apply to clinical training activities at all, the text of the regulation contradicts that view; it speaks of "costs," not "activities," and the term "costs" is used unconditionally. Thus, nothing in the anti-redistribution clause suggests any exclusion of clinical activities, including the clinical GME programs at issue here, from the anti-redistribution principle. Only new or unprecedented costs incurred by a medical school in connection with a provider's GME programs may be reimbursed.

C. The Secretary's construction of 42 C.F.R. 413.85(c) does not lead to arbitrary results that are incompatible with the text and purpose of the Medicare Act. Section 1395x(v)(1)(A) of the Act confers broad authority on the Secretary to determine the "reasonable cost" of reimbursable medical services, and to determine the "items to be included" in such costs. The existence of outside sources of funding for educational activities is relevant to the Secretary's determination of the "reasonableness" of Medicare's payment for the same activities. Although the training received by interns and residents may benefit patients, Medicare's basic purpose is to pay for direct medical services to patients, not to fund medical education. The Secretary may choose to give effect to the basic purpose of the Program by making Medicare the payor of last resort for educational activities, and by placing principal funding responsibility elsewhere, *i.e.*, on the "community." Once outside funds have been made available

to support educational programs, it is within the Secretary's discretion to decide that support from Medicare is not needed to ensure that the provider will continue to carry on its educational activities, and that limited Medicare funds would best be applied elsewhere.

D. The materials cited by petitioner and its amici lend no support to the argument that the Secretary has previously applied 42 C.F.R. 413.85(c) in a manner inconsistent with her position in this case. Indeed, most of those documents—which include internal operating guidelines issued by the Heath Care Financing Administration (HCFA), internal HCFA memoranda, and agency responses to public comments concerning various proposed regulations—did not even discuss the anti-redistribution principle. For the most part, they addressed other aspects of reimbursement of medical education costs. The fact that the Secretary did not discuss the regulation on a particular occasion (or in response to an inquiry directed to another subject) does not change the basic policy as espoused in 42 C.F.R. 413.85(c), nor can a contrary policy be inferred from such silence.

ARGUMENT

UNDER 42 C.F.R. 413.85(c), PETITIONER IS NOT ENTITLED TO MEDICARE REIMBURSEMENT FOR THE COSTS OF ITS GRADUATE MEDICAL EDUCATION PROGRAMS THAT WERE PREVIOUSLY ABSORBED BY ITS AFFILIATED MEDICAL SCHOOL

A. Reimbursement Of Such Costs Would Violate The "Anti-Redistribution" And "Community Support" Principles Under The Secretary's Interpretation of 42 C.F.R. 413.85(c)

When he promulgated the educational activities regulation at the inception of the Medicare Program, the Secretary exercised his express statutory authority to adopt

regulations for determining what shall be considered the "reasonable cost" of delivering patient care services to Medicare beneficiaries, as well as what items shall "be included[ ] in determining such costs." See 42 U.S.C. 1395x(v)(1) (1970).[9] As the Secretary recognized, Congress did not intend that Medicare should bear, as part of the "reasonable cost" of patient services, the full expense of educational activities undertaken by hospitals and other providers. The Senate and House Committee Reports on the Medicare Act contemplated a more measured approach:

> Many hospitals engage in substantial educational activities, including the training of medical students, internship and residency programs, the training of nurses, and the training of various paramedical personnel. Educational activities enhance the quality of care in an institution, and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program.

S. Rep. No. 404, 89th Cong., 1st Sess. Pt. 1, at 36 (1965) (J.A. 32); H.R. Rep. No. 213, 89th Cong., 1st Sess. 32 (1965) (J.A. 31-32).

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[9] The regulation was first issued on November 22, 1966 (see J.A. 34) and was designated 20 C.F.R. 405.421 (1967). In 1977, the regulation was recodified at 42 C.F.R. 405.421 (1977). See 42 Fed. Reg. 52,826. It was recodified at 42 C.F.R. 413.85 in 1986. 51 Fed. Reg. 34,790, 34,813. On September 22, 1992, the Secretary published proposed revisions of 42 C.F.R. 413.85 (see 57 Fed. Reg. 43,659-43,673 (J.A. 45)), but those revisions have not yet been adopted in final form.

The Medicare regulation governing the reimbursement of providers' educational activities, 42 C.F.R. 413.85, as interpreted and applied by the Secretary, implements this congressional intent. In subsections (a) and (g) of 42 C.F.R. 413.85, the Secretary has prescribed a method for calculating the "net cost of approved educational activities" that may be included in a provider's allowable costs. Subsection (c) makes clear, however, that "the costs of such educational activities should be borne by the community." Thus, reimbursement of net costs of educational activities is subject to the further condition that Medicare will "participate appropriately in the support of these activities" only "[u]ntil communities undertake to bear these costs." Finally, the regulation states that "it is not intended that [the Medicare Program] should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units."

The Secretary interprets 42 C.F.R. 413.85(c) to establish a broad "community support" principle that bars reimbursement of costs incurred in connection with a provider's educational programs if those costs have previously been paid by the community. Under the regulation, it is only *until* a provider's education costs are funded out of other public and private sources that Medicare will provide funds to pay such costs. That limitation is consistent with the expectation of Congress that "a part of the net cost of [educational] activities * * * should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program," only "*until* the community undertakes to bear such education costs in some other way." S. Rep. No. 404, *supra,* Pt. 1, at 36 (emphasis added); H.R. Rep. No. 213, *supra,* at 32 (emphasis added). Because Medicare, as third-party payor, assumes responsibility only until such time as the community undertakes support (and not thereafter), it

follows that, if educational costs have historically been paid by the community, Medicare will not thereafter assume the burden of paying them. That rule forecloses resort to Medicare if the level of community support that was once available is subsequently reduced. It thereby avoids any incentive for the community to withdraw its support (and for the provider or its affiliated medical school to reduce their efforts to obtain such support), and to shift the costs to Medicare.

In implementing the community support principle in a case such as this, the Secretary in effect presumes that, if costs for educational programs have been incurred in the past by an affiliated educational institution and have not previously been charged by the provider to Medicare, the costs have instead been paid by the affiliated educational institution out of other sources of funding in the community.[10] The sources of funding upon which medical schools ordinarily draw—tuition, grants, gifts, and donations—are considered by the Secretary to qualify as "community support." See, *e.g.*, *Board of Trustees* v. *Sullivan*, 763 F. Supp. 178, 189-191 (S.D. Miss. 1991) (accepting Secretary's position that provider's costs for nursing education are not reimbursable when "State appropriations, along with tuition revenues and grants," have in the past "fully provided for the entire expenses of the School of Nursing").

The Secretary's interpretation of the "anti-redistribution" clause of the regulation reinforces the community support principle. It focuses on a common form of community support for a provider's educational activities: the

[10] That presumption also applies (absent evidence to the contrary) to costs incurred in the past by the provider itself, but not previously charged by it to Medicare. The application of a presumption of "community support" in that setting is not at issue in this case.

payment of some costs associated with a provider's educational programs by that provider's affiliated medical school. Under the anti-redistribution clause, any attempt to pass on to Medicare costs that have previously been paid by a medical school, even if incurred in connection with the provider's clinical education activities, would be forbidden as a "redistribution of costs" from an educational unit to a patient care unit. The result, in a sense, is to consider financial support by an affiliated medical school for any aspect of the provider's educational programs as a form of "community support."[11] It therefore furthers Congress's intent when it established the Medicare Program that the community is the preferred source of support for educational programs in hospitals and that Medicare should be a payor of last resort.

The Secretary's approach is consistent with the background of the Medicare Program in another respect as well. Section 1395x(v)(1)(A) requires the Secretary, in prescribing reimbursement regulations, to "consider * * * the principles generally applied by national organizations." 42 U.S.C. 1395x(v)(1)(A). Pursuant to that statutory directive, Social Security Commissioner Ball stated during hearings on the original Medicare legislation that he would generally "expect to follow" the "principles of payment for hospital care" set forth in a 17-page pamphlet produced by the American Hospital Association (AHA). See *Medical Care for the Aged: Executive Hearings Before the House*

[11] Viewed from that perspective, the anti-redistribution language serves to clarify that although the general "related organizations" regulation (42 C.F.R. 413.17) might otherwise permit a provider to "pass through" to Medicare the costs incurred by an affiliated medical school in support of the provider's educational programs, a medical school will nevertheless be regarded as part of the "community" for purposes of 42 C.F.R. 413.85(c), so that payment of costs by a medical school will be regarded as a form of "community support."

Comm. on Ways and Means, 89th Cong., 1st Sess. Pt. 1, at 142 (1965); see AHA, *Principles of Payment for Hospital Care* (rev. Aug. 1963) (*excerpted at* J.A. 33). Commissioner Ball further stated that Medicare "would be following" the AHA's *Principles of Payment for Hospital Care* as they related to "teaching and nursing education costs." *Executive Hearings, supra*, at 784.

Section 2.302 of the AHA's *Principles of Payment for Hospital Care* stated that "[i]deally, the cost of educating and training" health service personnel "should be financed by the whole community through a combination of public resources and private contributions." See J.A. 33. Section 2.302 went on to state that, although it "will be necessary" that the cost of educational programs be "considered as a factor in determining reimbursement cost [*sic*] of hospital service until the community is prepared to assume this educational responsibility," hospitals and third-party purchasers "must seek methods for transferring this cost to the whole community through concerted joint effort." *Ibid.* The AHA therefore recommended (in language echoed in the committee reports on the Medicare Act) that educational costs be "considered as a factor in determining reimbursement cost [*sic*] of hospital service" by a third-party payor (such as Medicare) "until the community is prepared to assume this educational responsibility." *Ibid.* The "anti-redistribution" and "community support" principles in 42 C.F.R. 413.85(c), as interpreted and applied by the Secretary, conform to the AHA's suggested approach.

B. The Secretary's Interpretation Of The Anti-Redistribution And Community Support Language Of 42 C.F.R. 413.85(c) Is Reasonable And Entitled To Deference

The educational activities regulation, as interpreted by the Secretary, requires rejection of petitioner Hospital's claim for reimbursement under Medicare for the medical education costs at issue here, since "[i]t is uncontroverted that the excess costs claimed by the Hospital in fiscal year 1985 previously were borne by the Medical School." Pet. App. 22a. Petitioner contends that the Secretary's interpretation of her own regulation is erroneous. That contention is without merit.

As previously noted, the Secretary has an explicit mandate to formulate regulations to define what reimbursement is due under the Medicare program. 42 U.S.C. 1395hh, 1395x(v)(1)(A). In view of that mandate, her regulations giving content to the statutory scheme may be set aside only if they are arbitrary, capricious or manifestly contrary to the Act. *Sullivan* v. *Zebley*, 493 U.S. 521, 528 (1990) (quoting *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837, 843-844 (1984)); see *Batterton* v. *Francis*, 432 U.S. 416, 424-426 (1977).

Furthermore, it is axiomatic that the Secretary must be accorded the broadest possible discretion in interpreting the implementing regulations. See *Udall* v. *Tallman*, 380 U.S. 1, 16 (1965) ("[w]hen the construction of an administrative regulation rather than a statute is in issue, deference is even more clearly in order"). The administrative interpretation must be given "controlling weight unless it is plainly erroneous or inconsistent with the regulation." *Id.* at 16-17 (quoting *Bowles* v. *Seminole Rock & Sand Co.*, 325 U.S. 410, 414 (1945)); see *Martin* v. *OSHRC*, 499 U.S. 144, 150-151 (1991); *Robertson* v. *Methow Valley Citizens Council*, 490 U.S. 332, 359

(1989). The Court has been "properly hesitant to substitute an alternative reading for the Secretary's unless that alternative reading is compelled by the regulation's plain language or by other indications of the Secretary's intent at the time of the regulation's promulgation." *Gardebring* v. *Jenkins*, 485 U.S. 415, 430 (1988). Deference is all the more warranted where, as here, the question of interpretation arises under "a complex and highly technical regulatory program," in which the identification and classification of relevant criteria "require significant expertise, and entail the exercise of judgment grounded in policy concerns." *Pauley* v. *BethEnergy Mines, Inc.*, 111 S. Ct. 2524, 2534 (1991).[12]

The Secretary's interpretation of 42 C.F.R. 413.85(c) is, at the very least, a reasonable construction of the language of the regulation itself. In fact, the district court concluded that the Secretary's interpretation is not merely one of several permissible readings, but the only reasonable one. See Pet. App. 21a-22a (agreeing with the Secretary that "the regulation admits of *only one* interpretation" (emphasis added)). In particular, the final clause of 42 C.F.R. 413.85(c) states that, although Medicare will make reimbursement for some medical education costs, "it is not intended that [the Medicare Program] should participate in increased costs resulting from redistribution of costs from

[12] The courts of appeals uniformly have recognized that deference to the Secretary's interpretations of regulations implementing Medicare's complex reimbursement scheme is particularly appropriate. See, *e.g.*, *University of Cincinnati* v. *Heckler*, 733 F.2d 1171, 1173-1174 (6th Cir. 1984) (deference should be accorded "especially in areas like Medicare reimbursements"); *Butler County Memorial Hosp.* v. *Heckler*, 780 F.2d 352, 356 (3d Cir. 1985) ("deference is especially appropriate"); *Abbott-Northwestern Hosp., Inc.* v. *Schweiker*, 698 F.2d 336, 340 (8th Cir. 1983) (same); *Cheshire Hosp.* v. *New Hampshire-Vermont Hosp. Serv., Inc.*, 689 F.2d 1112, 1117 (1st Cir. 1982) (same).

educational institutions or units to patient care institutions or units." Yet that is precisely what petitioner seeks to accomplish here. Moreover, the regulation states that Medicare will in any event support educational activities only "[u]ntil communities undertake to bear these costs"; the community has already borne the costs at issue here through the non-Medicare resources at the Medical School's disposal. In this respect as well, the text of 42 C.F.R. 413.85(c) forecloses petitioner's contention that it may insist that Medicare now bear that burden.

Although petitioner launches a sustained attack on the Secretary's interpretation of the "community support" language, it fails to provide any alternative explanation of how the community support principle should be applied. Petitioner does not describe the circumstances in which communities will be regarded as bearing the costs of educational activities, so that Medicare will have no obligation to do so. Because it is difficult to conceive of an alternative reading of the regulation's community support and anti-redistribution language that would permit the reimbursement of the disputed costs in this case, it is not surprising that petitioner and its amici essentially ignore the clear language of the regulation.[13]

[13] Rather than supplying an alternative reading of the text of 42 C.F.R. 413.85(c), both the Hospital and its amici suggest that it is merely "precatory and advisory" and thus lacks any independent force. See Pet. Br. 31-32 (suggesting that the regulation establishes a "precatory 'ideal' "); AHA Br. 12, 14-15. The key passages in the regulation, however, set forth specific conditions on Medicare funding: educational costs will only be paid "*[u]ntil* communities undertake to bear these costs" (emphasis added), and the "redistribution of costs" from educational institutions to patient care institutions does not trigger an entitlement to reimbursement. Those phrases quite precisely limit the circumstances under which Medicare reimbursement will be made available to pay the costs of a provider's educational programs.

Petitioner and its amici do assert (Pet. Br. 20-21; AHA Br. 14-17), without support, that the anti-redistribution clause does not apply to costs of clinical training at all, but only to costs of the classroom training provided by educational institutions to the provider's clinical trainees (such as paramedics and nurses) and others (such as medical students). See also *Ohio State University* v. *Secretary, United States Dep't of Health & Human Services*, 996 F.2d 122, 124 (6th Cir. 1993) (*reproduced at* Pet. App. 71a), petition for cert. pending, No. 93-696 (filed Nov. 1, 1993). In other words, the anti-redistribution clause must be construed as selectively affecting only the costs of certain *non*-clinical activities. Because GME trainees (interns and residents) receive no classroom training at the Medical School, the anti-redistribution regulation, as so construed, would have no effect whatsoever on the availability of reimbursement for the Medical School's costs of training them.

The problem with this position is that it rests on a serious distortion of the terms of the regulation itself. As noted above, the regulation speaks of "costs," not "activities." Moreover, the term "costs" is used unconditionally. The proscription against redistribution is not limited to the costs of certain selected activities (classroom instruction) carried on by an educational unit. Nor does the anti-redistribution clause suggest any exclusion from its reach for the costs of any other activities carried on by educational units, such as clinical instruction of the provider's trainees by medical school faculty, or the administration of a hospital's clinical program by medical school personnel. In short, the interpretation of the anti-redistribution clause advanced by petitioner and its amici is far less consistent with the regulation's unqualified language than the Secretary's construction.[14]

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[14] In contending that the anti-redistribution regulation applies solely to non-clinical, classroom costs of training, amici AHA *et al.* rely (Br. 16-17) on Section 404.2 of the Provider Reimbursement Manual (PRM) (see J.A. 56-58), which concerns reimbursement of costs of approved nursing and paramedical education programs. PRM Section 404.2, however, supports the Secretary's interpretation.

To enhance the supply of trained nurses to staff their facility, Medicare providers may either support hospital-based nursing programs or may sponsor such programs in conjunction with affiliated or non-affiliated educational institutions. Unlike GME programs, which typically consist exclusively of clinical training on the provider's premises, nursing programs include both classroom and clinical components. Because the classroom portion of the program contributes to the overall education of the same nurses who participate in the clinical portion, classroom costs are chargeable to Medicare as costs "related to" patient care. See 42 C.F.R. 413.9(a). (In contrast, no classroom expenses incurred at an affiliated medical school would be chargeable to Medicare in connection with a provider's GME program. Interns and residents have already completed their classroom training, often at a non-affiliated institution, before they enroll in a provider's GME program. By the same token, the medical students trained at the provider's affiliated school do not care for patients as part of a provider's GME program, and thus their classroom training also is unrelated to care of the provider's patients.)

PRM Section 404.2 notes that, when the provider operates both portions of a nursing program, both classroom and clinical costs are ordinarily allowable. It further notes that when a non-provider operates the educational program, the clinical training portion generally is conducted in a provider or other health care setting and the costs incurred by the provider for clinical training therefore are allowable; but classroom costs paid by the provider to the educational institution for classroom instruction are allowable only if certain criteria are met, including that the "provider's support does not constitute a redistribution of non-provider costs to the provider." J.A. 56-57. Of particular relevance here, PRM Section 404.2 then states: "If the non-provider reduces its costs due to receiving provider support, such reduction constitutes a redistribution of cost from an education institution to a patient care institution and as such is not an allowable provider cost." J.A. 57. The result petitioner seeks to ac-

Even if that were not so, however, the Secretary's construction is, at the very least, a reasonable one. According

to the Secretary, the regulation covers the redistribution of *any* cost incurred by a medical school in connection with a hospital's educational program, whether that cost relates to the clinical or the classroom portion of training. Although such costs, if allowed, are chargeable to Medicare by the provider under the "related organizations" regulation, 42 C.F.R. 413.17 (see Pet. App. 63a), the availability of reimbursement of those costs is subject to the condition in 42 C.F.R. 413.85(c) that the charge not represent a redistribution of costs from one entity to another. The most natural reading of that language—indeed, the only plausible one—is that a cost *previously* incurred and paid by a medical school cannot be "includable in the allowable cost of the provider." See 42 C.F.R. 413.17(a). Only new or unprecedented costs incurred by a medical school in connection with a provider's GME program may be reimbursed. Thus, for example, if a medical school set up an office to administer a GME program newly established by its provider affiliate, the resulting costs could be passed on to Medicare through a claim by the provider for reimbursement of its overall costs of patient care. Since, in that example, the costs had not previously been borne by the medical school (because they had never

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complish—the redistribution of costs from the Medical School to the Hospital so that the latter can claim them under Medicare—is functionally indistinguishable from the practice condemned in the quoted passage. Contrary to amici's contention (AHA Br. 16-17 & n.9), the fact that this Section of the PRM does not discuss how the anti-redistribution and community support principles affect reimbursement of the *clinical* portion of non-provider operated nursing and paramedic programs does not mean that those principles do not apply to clinical costs as well. The quoted passage states a general rule, with no suggestion that the rule is confined to the redistribution of classroom costs.

before been incurred), charging the costs to Medicare would not be premised on a redistribution of costs from the school to the provider.[15]

Nor is the Secretary's construction in any way inconsistent with other subsections of the same regulation, or with other regulations governing Medicare reimbursement.

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[15] Contrary to petitioner's suggestion (Pet. Br. 25-26), the preamble to recent proposed regulations relating to providers' educational programs (see 57 Fed. Reg. 43,659 (1992) (*excerpted at* J.A. 45-55)) does not "state[ ] categorically" that the anti-redistribution principle in 42 C.F.R. 413.85(c) is "inapplicable to [GME] costs incurred by a related-medical school as provided in [Intermediary Letter No. 78-7 (Feb. 1978)]", discussed at page 32, *infra*. The statement quoted by petitioner concerns the application of the "related organizations" regulation, 42 C.F.R. 413.17, and explains that, with the exception of certain GME costs incurred by affiliated medical schools, educational costs of related organizations must be directly reflected on the accounts of providers before they will be recognized by Medicare. Otherwise, the preamble states, the anti-redistribution principle would be violated. 57 Fed. Reg. 43,668 (1992) (J.A. 53-54). The fact that Medicare will recognize some GME costs reflected on accounts of a related medical school, however, does not mean that it will recognize all of them, or that *no* claim for costs previously incurred by a medical school can ever violate the anti-redistribution clause.

In fact, the proposed regulations include a definition of the phrase "redistribution of costs" that confirms the Secretary's interpretation of 42 C.F.R. 413.85(c). It defines the term as "an attempt by a provider to increase the amount, or to expand the types, of the costs of educational activities that are allowed for Medicare payment purposes by claiming costs that previously were not claimed by the provider." 57 Fed. Reg. 43,672 (1992). That definition does not represent any change in policy. The proposed regulations are primarily intended to implement statutory amendments concerning nursing and other paramedical (*i.e.*, non-GME) educational programs, which had never been brought under the "base year" methodology made applicable to GME programs in 1985. See *id.* at 43,660 (J.A. 46). But the proposed amendments otherwise are intended to "restate or clarify • • • current policies governing [educational] costs." *Ibid.* (J.A. 45).

Petitioner and its amici complain that the disallowance of costs that previously were paid by the community (including costs paid by an affiliated medical school) cannot be squared with the evolution of subsection (g) of 42 C.F.R. 413.85, which provides for the offset of certain specific sources of funding in calculating the "net cost" of educational activities eligible for Medicare reimbursement. Although subsection (g) originally provided for an offset for "grants, tuition, and specific donations," it was later revised to eliminate the offset for grants and donations.[16] Petitioner objects that, having "eliminated [grants and donations] from the category of funds which must be deducted from full costs to determine allowable GME costs in subsection (g), the Secretary in effect attempts to read them back into the regulation under vague 'community support' language of subsection (c)." Pet. Br. 34; see also AHA Br. 13.

Subsection (c) does not negate the effect of subsection (g), however, because the "offset" and "community support" provisions each play a distinct and cumulative role in determining a provider's ultimate entitlement to reimbursement. Although both regulations are concerned with the effect of outside sources of funding, subsection (g) calculates "net cost" as a function of the availability of outside funds during the cost reporting period in question. Subsection (c), in contrast, is concerned with whether

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[16] Subsection (g) currently requires the offset of any "revenues from tuition" received by the cost-paying institution. The original version of the regulation required the offset of revenues from "grants, tuition, and specific donations." See 20 C.F.R. 405.421(b)(2) (1967). The regulation was subsequently modified to preclude the offset of grants and donations designated for GME programs in specified categories (45 Fed. Reg. 51,783, 51,786-51,787 (1980)), and, finally, to eliminate the offset of any grants or donations entirely (49 Fed. Reg. 234, 296, 313 (1984)). See AHA Br. 12-13; Pet. Br. 33.

costs have historically been paid from sources other than Medicare in the *past*. Thus, each regulation places an independent condition on the availability of reimbursement under Medicare, and each must be satisfied before payment can be made. For example, if a provider claims a cost for a new educational service that has never previously been provided (and thus never been paid for by the community), reimbursement would be permitted under subsection (c). Cf. *St. John's Hickey Memorial Hosp., Inc.* v. *Califano*, 599 F.2d 803, 810 (7th Cir. 1979) (regulation does not bar reimbursement where affiliated college establishes new educational program). Under subsection (g), however, the amount of reimbursement to which the provider would be entitled would be calculated as the cost of the program minus the amount the provider received in tuition payments.

C. The Secretary's Construction Of 42 C.F.R. 413.85(c) Is Not Arbitrary Or Capricious Or Inconsistent With The Medicare Act

Petitioner and its amici also claim (Pet. Br. 36-37; AHA Br. 22-23, 25-27) that the Secretary's construction of the educational activities regulation should be rejected because it leads to "arbitrary" results that are incompatible with the text and purpose of the Medicare statute. They contend that denying reimbursement based on a provider's failure to claim costs in the past is inconsistent with the statutory definition of "reasonable costs." 42 U.S.C. 1395x(v)(1)(A). That Section, however, confers very broad authority on the Secretary to determine the "reasonable cost" of a medical service that would be entitled to reimbursement. That authority encompasses the discretion to determine the "items to be included" in the category of reimbursable services. 42 C.F.R. 1395x(v)(1) (1970). Thus,

the Secretary may decide what types of services are allowable—*i.e.*, are covered by Medicare at all—as well as the level at which those services are reimbursed.

Petitioner's argument rests on the false assumption that the existence of outside sources of funding for educational activities is irrelevant to the Secretary's determination of the "reasonableness" of Medicare's payment of the costs of those activities. There is nothing arbitrary about the Secretary's refusal to pay for educational programs that have been previously funded, on a voluntary basis, by other sources, whether public or private. Although the training received by interns and residents in hospital GME programs may redound to the benefit of patients in a number of ways, Medicare's basic purpose is to pay for direct medical services to patients, not to fund medical education. It would not have been inconsistent with the "reasonable cost" language in Section 1395x(v)(1)(A) for the Secretary to have elected to exclude GME program costs from Medicare reimbursement altogether. The Secretary instead adopted regulations that permit reimbursement of a portion of such costs. In determining the extent to which federal funds earmarked for patient care should be used to support educational programs that do arguably advance Medicare's objectives, the Secretary had the discretion to make Medicare the payor of last resort, and to limit Medicare's responsibility by placing principal funding responsibility elsewhere, *i.e.*, on the "community."

The Secretary's application of the anti-redistribution and community support principles is, as we have discussed, consistent with congressional intent as manifested in the committee reports on the Medicare Act, and in the statutory directive that the Secretary follow payment principles "generally applied by national organizations"—*e.g.*, the "community support" principle set forth in the American Hospital Association's *Principles of Payment*

for Hospital Care. See pages 19-20, *supra*. Moreover, the Secretary's practice is grounded in the legitimate commonsense judgment that Medicare funding for a provider's educational activities is an effective use of scarce Medicare dollars only under limited circumstances—that is, only until such time as the community has undertaken to bear those costs. If a provider did not previously claim the costs, for whatever reason, then it is not an unreasonable assumption (at least absent evidence to the contrary) that the provider was able to conduct the programs despite the absence of Medicare funding because alternative sources of funding were found to pay the costs of the programs. Once other funds have been made available to support educational programs, it is within the Secretary's discretion to decide that support from Medicare is not needed to ensure that the provider will continue to carry on its educational activities, and that the limited funds available to the Medicare program would best be applied elsewhere.[17]

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[17] Petitioner and its amici suggest that inclusion of "hospital fees" or patient care revenues in the category of prior "community support" that would bar Medicare reimbursement for certain services (see Pet. App. 18a, 32a) is inconsistent with the Medicare Act's "cross-subsidization" provision, which directs that the Secretary's regulations ensure that "the necessary costs of efficiently delivering covered services" to Medicare beneficiaries not be "borne by individuals not so covered." 42 U.S.C. 1395x(v)(1)(A). See Pet. Br. 32, 36-37; AHA Br. 23-24, 26-27. The question whether the funding of educational programs using patient care revenues constitutes a form of "community support" is not presented by this case, because the GME costs in dispute were previously borne by the Medical School, not the Hospital, and fees paid by non-Medicare patients to the Hospital therefore were not a prior source of funding for the costs.

In any event, it is fully consistent with the "cross-subsidization" provision of Section 1395x(v)(1)(A) to take account of support furnished out of hospital fees. The cross-subsidization principle is not violated unless the costs allegedly being "shifted" are allowable Medicare costs.

D. The Agency Has Been Consistent In Its Interpretation Of 42 C.F.R. 413.85(c)

The materials cited by petitioner and its amici lend no support to the argument that HHS has previously applied 42 C.F.R. 413.85(c) in a manner inconsistent with the Secretary's position in this case. Indeed, most of those materials do not even discuss the anti-redistribution principle. Petitioner seeks to infer from that silence the existence of a contrary policy. Needless to say, however, the Secretary does not establish policy by omission.

Petitioner and its amici first point (Pet. Br. 22; AHA Br. 17-18) to an internal operating guideline issued by the Health Care Financing Administration (HCFA) in HHS in February 1978 that reviewed a "number of situations" relating to reimbursement of costs incurred by medical schools affiliated with providers. Intermediary Letter No. 78-7 (Pet. App. 64a-66a). The Intermediary Letter was concerned primarily with detailing the categories and amounts of educational expenses incurred by affiliated medical schools that might be allowable to providers. It did not purport to be a comprehensive review of all conditions that might be placed on reimbursement of educational costs, and it did not address the issue of redistribution at all.

Petitioner similarly relies (Pet. Br. 22-23) on an exchange of memoranda within HCFA in 1982 regarding the

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See *North Clackamas Community Hosp.* v. *Harris*, 664 F.2d 701, 707 (9th Cir. 1980) (Kennedy, J.). Under 42 C.F.R. 413.85(c), costs that do not satisfy the anti-redistribution and community support principles are not allowable costs, and Medicare reimbursement therefore is not available to help defray them. Where medical education costs are found to be allowable, they will be apportioned between Medicare and non-Medicare patients in proportion to the medical services received from the provider, in the same manner as other costs. Neither category will impermissibly subsidize the other.

University of Oregon's health training programs. Once again, however, the absence of discussion of the anti-redistribution principle by the HCFA central headquarters official in his response to the Regional Administrator scarcely manifests a contrary HCFA policy. Indeed, a subsequent memorandum issued in 1985 by the Director of HCFA's Division of Hospital Payment Policy pointed out that the 1982 central office memorandum "did not specifically discuss the policy with respect to the redistribution of costs from a medical school to a hospital," and stated that "[t]he fact that [the redistribution issue] is not mentioned in the subject memorandum does not change the basic policy as espoused in 42 CFR [413.85(c)]." J.A. 27.[18]

Petitioner and its amici next argue (Pet. Br. 25; AHA Br. 18-19, 20) that an inference favorable to their position may be drawn from the Secretary's "failure * * * to articulate a policy of redistribution" in response to public

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[18] In light of the 1985 memorandum specifically confirming the continued vitality of the anti-redistribution principle, the Director's failure to expound upon that principle in a letter she wrote to the Oregon Health Sciences University three months later (see J.A. 29-30), relied upon by petitioner (Pet. Br. 23-24), is of little moment, and certainly does not signify an abandonment of the agency's position on the anti-redistribution clause. (In a portion of the letter omitted from the Joint Appendix, HHS explained the disallowance of some of the provider's claims based on other grounds. See Pet. C.A. App. 118-119.)

Petitioner also relies (Pet. Br. 24 n.12) on a 1993 PRRB decision in claiming that HCFA failed to apply the anti-redistribution principle against the Oregon University Hospital Program. That PRRB decision concerned the Oregon Program's attempt to claim Medicare reimbursement for costs incurred between 1978 and 1981. As petitioner concedes, the PRRB never reached the issue of whether those costs might be disallowed under the anti-redistribution language in Section 413.85(c); it disallowed the costs at issue based on the Medicare reopening regulations.

comments concerning proposed regulations implementing the 1985 COBRA amendments, Pub. L. No. 99-272, § 9202(a), 100 Stat. 171 (1986), which established a "base year" for reimbursing health education costs. See 54 Fed. Reg. 40,286 *et seq.* (1989); pages 5-6, *supra*. The regulations, among other things, required a reaudit of providers' previously submitted cost reports for GME expenses incurred during the base year. The passage in the preamble to the regulations to which petitioner refers consists of a response to an inquiry by a commenter on the proposed regulations as to whether a provider is forbidden under the anti-redistribution principle in 42 C.F.R. 413.85(c) from collecting Medicare reimbursement for GME costs incurred by an affiliated medical school when "State appropriations or other funding sources are sufficient to cover the costs of operating the medical school." 54 Fed. Reg. 40,302 (1989) (J.A. 43). That inquiry concerned the issue of "offset"—*i.e.*, the effect of the availability of outside funding during the cost reporting year in question. It was not directed at the effect of the payment of costs through the use of public or private sources in *past* years (which is the concern of the anti-redistribution regulation). See pages 27-29, *supra*. Thus, it is not surprising that the Secretary's reply focuses on reviewing the proper application of subsection (g) of the regulation with respect to grants, but does not specifically address the anti-redistribution principle in subsection (c). See 54 Fed. Reg. 40,302 (1989) (J.A. 44-45).

Likewise, it is of no significance (see AHA Br. 20) that the Secretary did not discuss the community support and anti-redistribution principles in response to a suggestion by a commenter on the same regulations that hospitals should be able to introduce additional GME costs "not previously claimed, as well as misclassified costs," during the reaudits of base-year period cost reports authorized by

the regulations. 54 Fed. Reg. 40,301 (1989) (J.A. 42). The Secretary's response addressed the limited question of whether 42 C.F.R. 413.85(c) allows a provider to revise a base-year period cost report to include GME costs incurred by a related medical school in the base year that were inadvertently omitted in an initial cost report for that same year. 54 Fed. Reg. 40,301 (1989) (J.A. 42-43). It did not address the distinct question of whether mistakenly omitted costs would be reimbursable if they had not been claimed in cost reports for previous years and had instead been absorbed by the provider or an affiliated medical school in those years.

Finally, petitioner and its amici suggest (Pet. Br. 21, 29-30; AHA Br. 19, 24) that Medicare's willingness to pay claims for the costs of providers' educational programs during the year when those costs were first claimed demonstrates that the Secretary's enforcement of the community support and anti-redistribution principles is of recent vintage. They argue in particular that, because the Hospital's preexisting program must have been supported by the "community" prior to the filing of its first claim for educational costs in 1974, application of the Secretary's interpretation of the regulation would have barred reimbursement of the claim.

Petitioner's argument has little force, because it is not possible to determine at this point the extent to which, and why, the costs claimed in 1974 were considered by the intermediary to be reimbursable under the Secretary's regulation. In the first place, if a provider (rather than its affiliated medical school) has previously incurred such costs but has not claimed them under Medicare, reimbursement of those provider costs by Medicare for the first time would not constitute a redistribution of costs from an educational institution to a patient care institution in violation of the anti-redistribution clause of 42 C.F.R. 413.85(c), and the presumption of prior community

support in that setting might be rebutted in other respects. See note 10, *supra*. Moreover, any unprecedented costs incurred by the provider or its affiliated medical school—for example, costs for new programs, or the costs of expanding preexisting programs—could have been reimbursed without violating the community support or anti-redistribution principles. See PRM § 404.2 (J.A. 57). In short, because the details of the Hospital's cost reports for its GME programs prior to 1974 are not part of the record of this case, it is impossible to tell whether the initial decision to support petitioner's GME programs was consistent with the Secretary's interpretation of the regulation at issue.

Contrary to petitioner's suggestion (Pet. Br. 26), the absence until recently of administrative and judicial decisions reflecting the Secretary's interpretation of 42 C.F.R. 413.85(c) does not show that the Secretary only recently adopted that interpretation, or that the Secretary previously took a contrary position. There is a more plausible explanation for the dearth of controversy surrounding application of the educational activities regulation prior to the mid-1980's. As a practical matter, intermediaries experienced a surge in claims for costs incurred in connection with providers' educational programs following the changeover from the "reasonable cost" to the prospective payment system (PPS) of reimbursement for non-education costs after 1983. The revision in the Medicare reimbursement method for non-educational services, combined with increased costs and a diminution of financial support for educational programs in general, furnished an impetus for providers to ferret out previously unclaimed costs that could be attributed to the provider's educational activities, which were still being reimbursed on a "reasonable cost" basis. See, *e.g.*, J.A. 8-13. As a result, intermediaries invoked 42 C.F.R. 413.85(c) to reject claims for GME costs previously absorbed by a pro-

vider's affiliated medical school or otherwise supported by the community, which in turn led to review of these decisions by the Secretary and the courts.[19]

In sum, and contrary to petitioner's assertion (Pet. Br. 26), the Secretary's position in this case does not represent a repudiation of any longstanding interpretation of the regulation at issue, and there is no evidence that the Secretary's position is "newly arrived at" for the purposes of this case. The Secretary has consistently adhered to the position advanced here in other litigation concerning the application of this regulation to graduate medical education costs, see, *e.g.*, *Board of Regents of the Univ. of Minnesota* v. *Shalala*, 837 F. Supp. 303 (D. Minn. 1993);

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[19] That trend was noted in the decision of the Administrator in *University of Minnesota Hospitals & Clinics* v. *Blue Cross & Blue Shield Ass'n*, reviewing PRRB Dec. No. 91-D29, in which the Administrator observed that

> [a]s a result of PPS and the corresponding provision for pass-through medical education costs, it became apparent that teaching hospitals were attempting to claim costs not previously the responsibility of the Provider or reimbursed by Medicare so as to increase reimbursement in response to the medical education pass-through provisions of PPS.

Slip op. 8 n.16 (citing Medicare Regional Intermediary Letter No. 87-9 (Feb. 6, 1987), which noted that "some teaching hospitals are improperly claiming institutional costs not previously reimbursed by Medicare * * * for the first time"); accord, Medicare Contractor Regional Bulletin No. 87-4 (Mar. 4, 1987). We have lodged copies of these materials with the Clerk of this Court. See also testimony of Touche Ross & Co. employee Gaynor (J.A. 14-16) (agreeing that hospitals have been re-evaluating their practices "with respect to claiming medical school costs" because of reductions in state and private support for medical schools and diminished provider revenues due to "reimbursement reform and competition").

Ohio State University v. *Secretary, United States Dep't of Health & Human Services*, 996 F.2d 122, 124 (6th Cir. 1993), petition for cert. pending, No. 93-696 (filed Nov. 1, 1993); *Board of Trustees* v. *Sullivan*, 763 F. Supp. 178, 184-185 (S.D. Miss. 1991), and petitioner points to no case in which the agency has taken a different position.

* * * * *

In this case, the Secretary found that the disputed costs of the provider's GME programs had, in past years, been paid by its affiliated Medical School out of public and private funds supplied by sources other than Medicare. The district court did not disturb that finding, see Pet. App. 18a-19a, and its decision was affirmed by the court of appeals.[20] Under the Secretary's interpretation of 42 C.F.R. 413.85(c), which is reasonable and entitled to deference by this Court, the disputed expenses had thus been "borne by the community," Pet. App. 15a-16a, and could not in any event be redistributed from the Medical

[20] Petitioner states at one point (Pet. Br. 9) that, during the period relevant to this case, the "Medical School operated at a deficit." It cites in support an isolated assertion by one of its employees in the administrative proceedings that "[w]ithout taking into account such things as gifts and grants, alumni giving endowments, [the Medical School] operated at a deficit" in 1985. Although the existence of a *past* deficit incurred by a provider or medical school, if it could be directly tied to the burden of supporting an educational program, might serve to rebut the presumption of community support, that principle does not help petitioner here. First, the assertion by the Hospital employee in this case relates to a deficit in the cost reporting year, not in past years. Second, the Hospital employee's remarks are not probative of community support because the sources of funding that the employee excluded from consideration in determining whether the Medical School was operating at a deficit would count as sources of community support. The employee's testimony thus fails to reveal whether the Medical School would have run a deficit if those sources of funding had been considered.

School to the Hospital for purposes of Medicare reimbursement. Both courts below sustained the Secretary's interpretation and application of her own regulation to that effect, and this Court therefore should affirm the judgment below.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted.

DREW S. DAYS, III
Solicitor General

HARRIET S. RABB
General Counsel

DARREL J. GRINSTEAD
Associate General Counsel

HENRY R. GOLDBERG
Deputy Associate General Counsel

THOMAS W. COONS
Supervisory Attorney

Department of Health and Human Services

FRANK W. HUNGER
Assistant Attorney General

EDWIN S. KNEEDLER
Deputy Solicitor General

AMY L. WAX
Assistant to the Solicitor General

ROBERT V. ZENER
ROBERT D. KAMENSHINE
Attorneys

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